A Submission for the Record
By Maura D. Corrigan, Director
Michigan Department of Human Services
to the Subcommittee on Human Resources,
Committee on Ways and Means, House of Representatives
Re: The Protect Our Kids Act

Chairman Paulsen, Ranking Member Doggett, and Members of the Subcommittee:

Thank you for the opportunity to comment about the tragedy of child abuse fatalities in the U.S. and what may be accomplished through the Protect Our Kids Act and the National Commission to End Child Abuse and Neglect Fatalities. The Michigan Department of Human Services received more than 150,000 complaints of abuse and neglect last year. We also considered reports on the fatal abuse and neglect deaths of 127 Michigan children from 2009-2010. We are thus acquainted with the costs of these deaths to children, their families, our communities, and the professionals who must respond to these deaths.

We know that Chairman Dave Camp commissioned the GAO study to investigate the problem of child maltreatment fatalities after learning about the tragic deaths of several young children from Michigan. Our state learned many lessons from those deaths. We have implemented numerous improvements within law enforcement, forensic investigations, health care, child welfare and criminal justice. We are still learning and taking actions to keep children safe. Michigan's efforts to learn from these deaths could provide valuable assistance to the proposed national commission.

Our state has a very well established and sophisticated multi-agency process, managed by the Department but in collaboration with other agencies, to identify, count, study, and respond to child abuse fatalities. We work to identify the risk factors and failures in our child welfare system so we can better protect our children. For over a decade, our Department has funded the Michigan Child Death Review Program and Citizen Review Panel on Child Fatalities. We support the Michigan Public Health Institute's management of multi-disciplinary teams covering all 83 counties in the state. These teams are charged with discussing the circumstances of all child deaths to improve investigations, services, and agency policies and practices. They submit comprehensive case reports to the State. We participate in the National Child Death Review Case Reporting System, which has been essential in helping us to record the number and circumstances of child deaths. This system was highlighted in the GAO Report as an important means to improve national counting and reporting on child maltreatment deaths.

Michigan has a state level advisory panel that meets several times a year to identify systemic problems and to make recommendations to our governor and legislature on opportunities to prevent these deaths. The Child Death State Advisory Team also

functions as Michigan's federally mandated Citizen Review Panel (CRP) on Child Fatalities. The CRP meets quarterly to examine deaths of children who were involved in the child protection system. This examination is a specialized, multi-step process that involves the identification of cases with the assistance of DHS, the collection of relevant materials and a thorough case review.

Because of our focused, multidisciplinary approach, we now know a good deal about the profiles of children who die from maltreatment in our state.

In 2009 and 2010, local Child Death Review teams reviewed 127 maltreatment deaths (38 abuse-related and 89 neglect-related fatalities). When local teams review a child's death, they are asked whether they believe that someone caused or contributed to the child's death by any action or inaction on their part. These numbers represent those cases where the team concluded that abuse or neglect either caused or contributed to the child's death. These reviews showed that infants under age 1 and children ages 1-4 are at an increased risk of fatality over all other age groups. For 2009 and 2010 reviews, a larger percentage of the deaths attributed to neglect were to infants than in the previous two years. This finding is due in large part to local review teams increasingly identifying sleep-related infant deaths as neglect.[1]

The CRP on Child Fatalities looks specifically at deaths of children who had previous interaction with the child protection system. In 2011, the CRP reviewed 93 such cases—41% of those cases were found as child maltreatment related fatalities (14 abuse-related and 25 neglect-related). In both review processes, neglect-related fatalities greatly outnumber abuse-related fatalities, indicating the importance of accurately identifying and preventing child neglect.

We don't stop at understanding the circumstances in the lives of children who have died—we work to develop and act on recommendations to prevent other deaths and to improve our system. A study of six years of our reviews, published in the Journal, Child Abuse & Neglect, found that we were able to significantly decrease child abuse deaths correlated with improvements in practice.

As outlined in the article by V.J. Palusci, many system changes were implemented as a result of Michigan's Child Fatalities CRP. These include statewide training for physicians, a new statewide protocol to determine cause and manner of sudden child deaths, a new protocol for joint investigation, a birth match system linking birth certificates with CPS records, as well as new training for CPS workers and supervisors. The study identified decreases in child fatalities associated with findings from the reviews among children known within the child protection system. The system changes implemented could also be associated with those findings and potentially linked to the fewer child maltreatment deaths shown in the study.[2]

While we have been hard at work in our state to protect children, we applaud the efforts of this Subcommittee through your hearing on Child Abuse Fatalities in July 2011, the GAO report, and now the Protect Our Kids Act that will establish a national Commission

to End Child Abuse and Neglect Fatalities. We know firsthand that a focused, dedicated, and multi-disciplinary approach to understanding why children die can help to prevent these deaths. We believe the Protect Our Kids Act will help us move toward a comprehensive national strategy to combat the tragedy of child abuse fatalities. This bipartisan commission, empowered by Congress to thoroughly examine the scope of the problem of fatal child abuse, is much needed. The Commission can study and recommend improvements to federal, State, and local data collection systems; identify State models of effective child abuse fatality prevention and intervention practices for widespread dissemination; and recommend improvements to Federal policies and practices.

We strongly support your efforts and hope you move this bill out of committee and work towards its speedy passage. Support and guidance from this Commission is greatly needed to move forward in improving our systems and services to children. America's children living at risk of dying of abuse cannot wait.

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1. Child Deaths in Michigan: Michigan Child Death State Advisory Team Ninth Annual Executive Report: A Report on Reviews conducted in 2009-2010. Compiled by Michigan Public Health Institute under contract with Michigan Department of Human Services.

2. Palusci, V.J., et al. Effects of a Citizens Review Panel in preventing child maltreatment fatalities. Child Abuse & Neglect (2010), doi:10.1016/j.chiabu.2009.09.018